DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

REQUEST FOR RESTRICTION(S)

45 C.F.R. 164.522(a)

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in my care, and that IHS is not required to agree to the restrictions requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If IHS agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, IHS will request the provider to not further use or disclose that information.

I request the following restriction(s) on the use or disclosure of my protected health information:

_____

_____

_____ _____

Signature of Patient or Legal Representative Date
(If Legal Representative, state relationship to patient)

_____

Witness

☐ Accepted ☐ Denied

_____

(If accepted, state which of the restrictions accepted)

_____ _____

Signature of SUD/CEO or Designee Date

PATIENT IDENTIFICATION	NAME (Last, First MI)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

IHS-912-1(10/02)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

REQUEST FOR REVOCATION OF RESTRICTION(S)

45 C.F.R. 164.522(a)

I hereby revoke the following restriction(s) except to the extent that IHS has already taken action in reliance thereon.

_____

_____

_____ _____
Signature of Patient or Legal Representative Date
(If Legal Representative, state relationship to patient)

_____
Witness

IHS is revoking the following restriction(s):

_____

_____

_____ _____
Signature of SUD/CEO or Designee Date

PATIENT IDENTIFICATION	NAME (Last, First MI)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

IHS-912-2 (10/02)